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Contrary to the publication by Robson and Kirsch,[4] which reports an apparent prevalence of anti-HCV of 0,5 - 3,0% in first-time blood donors in Natal, we originally found a prevalence of 0,6 - 1,2% in a small collaborative study of 1 498 individuals.[5] The past year's screening has given us a more accurate assessment, principally owing to a much larger sample size and the use of automated instrumentation. Our current figures are not out of line with many other centres world-wide.[6] We would be surprised to find a significant difference in the rest of the South African blood donor population.

Although the screening of donated blood for anti-HCV is not mandatory in South Africa, we still believe that screening is in the best interests of the patient. The pool test provides a means to circumvent the high cost of screening single donations while assuring the patient of a safer blood supply. It is significant that the World Health Organisation has accepted the principle of pooling for financial reasons in its strategy to combat AIDS in Africa.

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ıral medicine — a specialty in its own right?

To the Editor: The 'Opinion' by Jaques[1] deserves serious attention from health planners and health educationists. In the rural areas, where more than 50% of the South African population still lives, there is a severe shortage of adequately trained medical personnel. I wish to support his argument that we need more advanced trained generalist physicians ('rural specialists').

I believe that we need to do the following to address the problem:

1. We need to expand the recently accepted principle of vocational training for family/general practitioners, on a voluntary basis with definite incentives. This would involve a full-time training period of 3 years, starting during the intern year, and making provision for the individual needs of the trainee.

2. Those wishing to practise in rural areas should increase their surgical skills and opportunities for general hospital-based care by training for 2 years in suitable secondary hospitals under supervision of basic specialists. The 3rd year of training would need to be in a primary care situation, such as a family practice (private practice track) or a state community health centre or polyclinic (public service track).

3. This vocational training should be co-ordinated by a central body consisting of the universities, the Academy of Family Practice, the College of Medicine of South Africa and the Medical Association of South Africa, under the supervision of the South African Medical and Dental Council. The central government should fund this whole programme through dedicated funding out of the primary and secondary care budget allocations.

4. We need to institute a national health insurance scheme which would cover basic medical care for all the citizens of this country, with built-in incentives for rural practitioners and vocational training. Remuneration to medical practitioners should be on a per capita basis, with higher fees in rural areas and for those with postgraduate vocational training. The State must also give incentives for more advanced training by remunerating those practitioners on the same level as specialists, using the existing family physician post structure. Posts at rural hospitals would thus attract and retain adequately trained generalists ('rural specialists').

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1. Jaques PH. Rural medicine — a speciality in its own right? (Opinion). *S Afr Med J* 1992; **81:** 589-591.

To the Editor: I agree with Dr Jaques[1] that there is a gap between the primary and tertiary levels of medical care and also that adequately trained doctors should be provided to fill it. However, I disagree with his proposal that another specialist group should be instituted for this purpose, because I am of the opinion that an appropriately trained and committed family physician would be able to perform these tasks.

We are faced with the problem of maldistribution of medical manpower and unfavourable living and working conditions in most rural regional hospitals. This problem could become a fascinating challenge to all the faculties of medicine in this country, and especially to the departments of family medicine. Each faculty should 'adopt' a number of these hospitals, or a region, and include it in their academic complex for training purposes. Involvement in the management of the health facility through departments of community health could also be a viable option.

The appropriate training of doctors in and for these hospitals or regions should be co-ordinated by the departments of family medicine with the necessary support from the specialist departments. In practice this would entail the establishment of posts for family practitioners/lecturers in conjunction with the specialist posts already available, which could be filled by senior registrars who could help with the in-service training in technical skills. Although the acquisition of technical skills is important, I have found in my own research[2] that patients view the affective capabilities of doctors as more important, and therefore training in both should be given. Another requirement would be for all the departments of family medicine to agree on a uniform curriculum for the M.Prax.Med. degree and to increase the minimum duration of training to 5 years, like in New Zealand.

By accepting this challenge academic medicine would respond to the dire needs of rural communities and fulfil its responsibility towards this neglected sector of our pop-

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ulation. South Africa does not need another specialist group — it needs committed, appropriately trained family physicians!

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1. Jaques PH. Rural medicine — a specialty in its own right? (Opinion). *S Afr Med J* 1992; **81:** 589-591.
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Dr Jaques replies: Thank you for giving me the opportunity to comment on Professor Erasmus's response to my 'Opinion' paper. It is gratifying to see how much interest there is in this serious problem.

I have no fundamental objections to the adoption by departments of family medicine of the various medical schools of the specific training needs for rural practitioners. At a WONCA workshop in Vancouver in May this year, there was a good deal of discussion on the problems of recruitment and retainment of medical practitioners in rural areas. The vocational training programmes for family practitioners of most universities in Canada as well as in Australia include a specific component to cover the additional skills required in isolated areas.

I think that at this stage in South Africa it is important to recognise the special skills required by rural doctors, to institute training programmes which should have a large 'in-service' component, and to create career structures to enable rural medical practitioners to enjoy status and lifestyle equivalent to those of their colleagues in urban areas.

I believe that the more discussions we can have on the subject the sooner a solution will become apparent.

Foreign graduates and registration requirements

To the Editor: The article by Dr Kemp[1] rightly pinpoints the many frustrations experienced by doctors working in rural hospitals. It is not the the first time that this problem has been aired.[2] Of some concern to an expatriate are the repeated insinuations against medical practitioners from overseas.[1-2] Dr Kemp exposes his dissatisfaction and grievances with a system that frustrates him financially and intellectually. For reasons beyond my understanding these grievances are intertwined with complaints concerning expatriate doctors.

Working in rural hospitals can be either a choice or an imposition. Fully registered doctors, as South Africans are, can make that choice either for humanitarian reasons, or with the main purpose of making their 'experience' before going into private practice. Expatriate doctors, with few exceptions, are granted limited or restricted registration which gives them access only to government hospitals and bars them from private practice. This is a way to ensure (minimum) staffing of public hospitals and is no threat to South African nationals, most of whom are not interested in a prolonged stay in the public service. This is clearly demonstrated by the well-known difficulties experienced in academic and teaching hospitals, which had to grant their full-time medical staff the opportunity to improve their income through part-time private practice. Otherwise they would have left the public service.

Dr Kemp[1] and others[2] are dissatisfied with overseas doctors. I'd like to refresh some memories: less than 2 years ago the RSA was suffering an estimated shortage of around 5 000 doctors. Last year an opinion survey conducted at the University of Cape Town medical school[3] revealed that more than 50% of medical students were considering emigration. Apparently this prospect was so alarming that the South African Medical and Dental Council[4] even considered compulsory community service for medical graduates. This was of such concern to medical students[3] that the plan was dropped.

The major complaint concerning expatriate doctors relates to their alleged inexperience and inadequacies.[1-2] I strongly resent this sort of statement, which places all of us in the same 'basket'. The medical community is a human community with both bright, honest and hard-working and unintelligent, dishonest, devious and lazy members, whatever their country of origin. Furthermore, all of us were inexperienced at some time. Mere restricted registration does not mean that required standards are not met. If that were true, it would be shameful for any medical council to allow staffing of rural hospitals with substandard doctors. All overseas doctors are not brilliant and highly qualified, but this equally applies to South African nationals. Two recent surveys[5,6] of 'substandard' knowledge and practice of anaesthesia in teaching, private, regional and peripheral hospitals show that medical inadequacy is not limited to expatriate doctors!

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Dr Kemp replies: Dr Van Bogaert has focused on a single statement in my article and seems to have missed the main thrust. I had no intention to indulge in 'foreign doctor bashing'. My main aim was to isolate some of the difficulties experienced in the smaller community hospitals and to suggest ways of encouraging more doctors to spend longer periods in the periphery. I also did not mean to imply that all doctors with limited registration are inexperienced. However, many of the expatriate doctors with limited registration employed in KwaZulu recently had